Virtual PACE Quality Measurement, Oversight, & Incentives
Differences from Financial Alignment Demonstration Model

Reporting Measures and Performance Improvement

The Wisconsin Department of Health Services (DHS) did not disagree with the basic approach proposed for Financial Alignment Demonstrations (FAD) in the requirements grid released last winter, wherein CMS and the State determine applicable standards and jointly conduct a single quality management and reporting process. The concern here was only that the Virtual PACE demonstration includes an integrated quality oversight process and a set of measures relevant to the specific population, rather than simply adopting Medicare-based processes and measurements. However, the draft FAD quality measures document provided in May does appear to adopt the Medicare Advantage HEDIS measures and allow for additional Medicaid measures to be tacked on by the State. Wisconsin does disagree with using standard Medicare Advantage measures and processes as the basis for Virtual PACE.

Quality Incentives

The DHS proposal varies from the Financial Alignment Model on this element. As stated in the proposal submitted April 26, 2012, DHS proposes **not** to use quality bonuses, incentives, or withholds in the initial pilot period. Per the proposal, in the first year Wisconsin will "establish a consistent and meaningful quality measurement methodology that will be used for quality bonuses and/or withholds in years two and three."[1] This various from the Financial Alignment Model's parameter wherein withholds are proposed for each of years one, two, and three.

Proposed Approach

Reporting Measures and Performance Improvement

Selection of Specific Measures

DHS continues to propose a joint process of measure selection as stated in its proposal. Specific measures are not proposed here, as DHS and CMS must agree on a general approach before specifying measures in an MOU or in three-way CMS-DHS-ICO contracts. The State may also seek additional input from its advisory committees. However, the starting point and approach to specifying these measures can be somewhat further refined.

DHS proposed considering measures from a wide variety of data sources and existing programs, and then integrating those measures and aligning them with nursing home measures to produce a unified, integrated quality model. DHS now further proposes that the starting point for selecting these measures be the PACE Level One Reporting Requirement measures[2] and the Long Stay Quality Measures subset of the CMS Nursing

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[1] http://www.dhs.wisconsin.gov/wipartnership/pace/pdf/proposal042612.pdf, Section E, page 24
[2] http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//pace111c10.pdf

Home Quality Measures endorsed by the National Quality Forum (NQF).[3] This provides a basic set of managed care measures, and adds long stay nursing home specific measures that would be calculated from Minimum Data Set (MDS) data that must be collected anyway.

This is proposed as a starting point only; measures may be added, deleted, replaced, or redefined. This may occur to eliminate duplicate measures between the two lists, such as immunizations, or to more appropriately measure quality for this program and population. For example, one Long-Stay Quality Measure on the NQF-endorsed list is the percentage of residents who lose too much weight. Stakeholders have commented that measuring weight loss at the end of life may be inappropriate as such residents may appropriately choose not to eat. Refining the measures may thus include removing terminally ill residents from the calculation of that percentage.

Revisions, additions, and deletions to specific measures should be further negotiated between CMS and DHS, with input from stakeholders. Additional refinements might be proposed based on the program evaluation design that will be deliverable to DHS in early Fall, as discussed in the Virtual PACE proposal. DHS proposes that a key consideration for any additional measures be their relevance to this specific population and program. As such, the NQF June 2012 report, "Measuring Health Care Quality for the Dual Eligible Beneficiary Population" would be a better start point in selecting additional measures than Medicare Advantage, since that report at least considers measures' applicability to a dual eligible population, if not specifically an institutionalized population. Measures should not be added simply because other demonstration plans or Medicare Advantage plans will be reporting them; if it is not an important measure for the long stay nursing home population specifically, then it is not a good point of comparison.

Data Sources for Measures

The NQF-endorsed Long Stay Quality Measures are derived from MDS data. This is a desirable data source as it is already collected for all nursing home residents at specified intervals; as the Virtual PACE program would not propose to change that, there should be no additional data collection or reporting burden in using MDS-derived measures.

PACE Level One Reporting Requirement measures are data that must be reported by ICOs. This would be an ICO contractual requirement.

Some form of beneficiary survey would provide another data source. This may include CAHPS and/or PEONIES surveys. DHS would seek to discuss the utility of each survey further with CMS and with stakeholders.

Encounter data may also provide another data source that could be utilized if additional encounter-based measures are developed and agreed upon.

Reporting Requirements and Processes

Existing MDS reporting requirements need not be altered. Processes for access to this data by ICOs, the State, and any contracted entities such as an EQRO or program evaluator should be developed.

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[3] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html

Assuming that HPMS will be the system used for at least some program functions, DHS would propose to use that for the plan-reported measures based on PACE Level One Reporting. This may require some modifications for Virtual PACE ICOs to access the module, to not require reporting on immunization or other measures duplicative of the Long-Stay Quality Measures, and to give any necessary entities access to those reports (DHS, EQRO, or program evaluator).

DHS expects that any surveys (CAHPS and/or PEONIES) would be administered by one of its contracted entities. A process will need to be developed to share those results with CMS or its program evaluators as needed.

ICOs will also be required to report encounter data; these requirements and processes will be separately negotiated with CMS.

Existing regulatory reporting requirements that nursing homes report certain allegations immediately will not be altered.

Improvement Plans/Programs

The DHS proposal for Virtual PACE included a requirement for ICOs to develop, implement, maintain, and evaluate a Quality Assessment and Performance Improvement (QAPI) program. This is based on the PACE QAPI requirements. DHS would propose to specifically adopt PACE requirements that the QAPI include measures demonstrating performance in five areas:

1) Utilization, such as decreased hospitalizations and ER visits
2) Caregiver and participant satisfaction
3) Outcome measures derived from assessment data including: physiological well being, functional status, cognitive ability, social/behavioral functioning and quality of life
4) Effectiveness & safety of services, including competency of clinical staff, promptness of service delivery, and achievement of treatment goals & measurable outcomes
5) Nonclinical areas such as grievance & appeals, transportation, meals, safety, and environmental issues.

Most of these domains are also covered in the specific measures and data sources already described. Utilization data may be derived from required encounter data, there will be some form of beneficiary survey, the MDS will provide a source of assessment data, and certain nonclinical areas are covered in the measures derived from PACE Level One Reporting Requirements. Thus, ICOs should be able to develop a QAPI program that is consistent with and based primarily on the same sources of data required for reporting.

QAPI programs should also align with the Division of Quality Assurance (DQA) requirement that nursing homes each have a Quality Assessment and Assurance Committee (QAAC). The QAAC meets at least quarterly and is charged with identifying quality deficiencies and putting systems in place to address them. The details of this alignment may vary depending on the business model. For example, if a nursing home is a part of an ICO formed from nursing home(s) and hospital(s) partners, then the QAAC(s) may develop QAPI programs. Otherwise, the ICO should consult with contracted homes' QAACs in developing and implementing QAPI programs to ensure

quality improvement efforts are aligned and not duplicative or conflicting. The QAAC and ICO will be expected to consider whether and how any quality deficiencies identified in regulatory surveys for nursing home certification should be addressed in the QAPI program.

Oversight Structures/Processes and External Organization

In the demonstration proposal, DHS proposed to have a program evaluation design deliverable by Fall 2012. This will include a quality oversight structure integrating requirements and processes from existing programs and nursing home regulatory requirements and processes. DHS would still propose to leverage this work in determining the structure and processes for ICO oversight. Specific CMS comments, suggestions, and requests for what this may look like would be helpful; Financial Alignment Model did not define the structure or process for oversight other than to establish a joint process as a parameter.

Quality Incentives

DHS continues to propose that incentives, bonuses, or withholds **not** be applied to payments in the first year of the pilot. As stated in the proposal, a workgroup would be formed in the first year to develop specific focus areas for quality incentives, bonuses, or withholds in subsequent years.

Appendix 1: NQF Long-Stay Nursing Home Quality Measures

Long Stay Quality Measures

- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of Residents who Self-Report Moderate to Severe Pain
- Percent of High-Risk Residents with Pressure Ulcers
- Percent of Long Stay Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Long Stay Residents Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Long-stay Residents with a Urinary Tract Infection
- Percent of Low-Risk Residents Who Lose Control of their Bowels or Bladder
- Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents Who Were Physically Restrained
- Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased
- Percent of Long-stay Residents Who Lose Too Much Weight
- Percent of Residents Who have Depressive Symptoms

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html

Appendix 2: PACE Level One Reporting Requirements

Described in Chapter 10 of the PACE Manual as follows:

"Level One Reporting Requirements refers to those data elements for monitoring that are regularly reported by PACE organizations via the Health Plan Management System (HPMS) PACE monitoring module. These monitoring elements are detailed in the HPMS PACE User's Guide, Fall 2005 (https://www.cms.gov/PACE/Downloads/hpmsmanual.pdf) and include:

- Routine Immunizations;

- Grievances and Appeals;

- Enrollments;

- Disenrollments;

- Prospective Enrollees;

- Readmissions;

- Emergency (Unscheduled) Care;

- Unusual Incidents; and,

- Deaths."

Chapter 10 of the PACE manual can be found online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c10.pdf. However, note that the HPMS PACE User Guide web address contained in the quoted section above results in an error message stating the page cannot be found.